IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

AMERICAN HOSPITAL ASSOCIATION, *et al.*, Plaintiffs, v. SYLVIA MATHEWS BURWELL, Defendant.	Civil Action No. 14-CV-851-JEB

PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT AND MEMORANDUM OF POINTS AND AUTHORITIES IN SUPPORT

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INTRODUCTION

The plaintiff hospitals, joined by the American Hospital Association (AHA), filed this suit in May 2014, seeking a writ of mandamus that instructs the Secretary of Health and Human Services (HHS) to comply with mandatory statutory deadlines. Since that time, there have been three full rounds of briefing on the appropriateness of mandamus relief: Plaintiffs' motion for summary judgment (and the Secretary's contemporaneous motion to dismiss) in this Court, Plaintiffs' appeal to the Court of Appeals, and the Secretary's motion to stay in this Court. After the most recent round, this Court suggested that the end of the merits dispute is near, as "[t]he balance of interests drives the conclusion that there are equitable grounds for mandamus." Mem. Op. 16 (Sept. 19, 2016), ECF No. 38. This motion for summary judgment formally requests that mandamus relief.

That leaves the question of remedies. The parties agree that the Secretary's statutory violations cannot be cured overnight. But the Secretary has treated difficulty as an excuse for inaction. In light of HHS's repeated refusal to make meaningful changes that address the backlog of administrative appeals, the Court should order the Secretary to implement three sets of practicable solutions: (1) offer reasonable settlements to broad groups of Medicare providers and suppliers; (2) delay repayment of at least some subset of disputed Medicare claims, and toll the accrual of interest on those claims for waiting times beyond the statutory maximums; and (3) impose financial penalties on recovery audit contractors (RACs) for poor outcomes at the administrative law judge (ALJ) level. The Secretary has the authority to implement each reform, which together will target the existing backlog of appeals and reduce the number of future appeals. The Secretary should be ordered to adopt some version of all three reforms.

In the alternative, if the Court wishes to frame its order more permissibly, it should demand clear numerical progress. Under that approach, it should require specified reductions of the backlog over the next several years, culminating in the elimination of the backlog by the end of 2020. And under either approach, the Court should also require the Secretary to file periodic status reports apprising the Court and Plaintiffs of her progress toward compliance with the statute.

BACKGROUND

Plaintiffs brought this mandamus action to require the Secretary to resolve the massive delays plaguing the Medicare appeals process. This Court initially dismissed Plaintiffs' complaint for lack of jurisdiction. *Am. Hosp. Ass'n v. Burwell*, 76 F. Supp. 3d 43 (D.D.C. 2014). The Court of Appeals reversed, holding that the complaint satisfied the threshold requirements for mandamus jurisdiction because the Secretary has a "clear duty" to comply with the statutory deadlines and is violating that duty. *Am. Hosp. Ass'n v. Burwell*, 812 F.3d 183, 190-192 (D.C. Cir. 2016). The Court of Appeals remanded the case for this Court to determine whether to grant mandamus, suggesting that mandamus would be appropriate if the Secretary and the political branches failed to make "meaningful progress" toward eliminating the backlog. *Id.* at 192-193.

Immediately after the case returned to this Court, the Secretary moved to stay the proceedings through September 2017, arguing that HHS and Congress should be given still more time to act. Def.'s Mot. for Stay (May 25, 2016), ECF No. 30. Plaintiffs opposed any further delays and requested that the Court enter an order granting mandamus. Pls.' Opp'n to Def.'s Mot. for Stay (June 13, 2016), ECF No. 31.

On September 19, this Court denied the Secretary's motion to stay. Mem. Op. 16. It analyzed the Secretary's proposed administrative fixes, including a limited settlement with

certain hospitals, some small changes to the appeals process, and a few tweaks to the Recovery Audit Program. *Id.* at 10-11. But those changes, it observed, are not enough. Even assuming that each "is implemented according to plan, the OMHA backlog will still grow every year between FY2016 and FY2020—from 757,090 to 1,003,444 appeals." *Id.* at 13 (emphasis in original). The prospect of a legislative fix, moreover, was no panacea: Congress is aware of the backlog and (presumably) of the Court of Appeals' decision, and it has taken no action. *Id.* at 15. Nor is there "evidence that any legislative action is imminent." *Id.* All told, "[t]he balance of interests drives the conclusion that there are equitable grounds for mandamus." *Id.* at 16.

The Court's September 19 opinion thus makes clear that summary judgment should be granted in Plaintiffs' favor. Indeed, at a status conference on October 3, the Court reiterated its intention to do just that. Plaintiffs now move for summary judgment. This motion incorporates by reference their prior motion for summary judgment—which focused on the merits of granting mandamus relief—and the statement of undisputed material facts contained therein. *See* Pls.' Mot. for Summ. J. (July 11, 2014), ECF No. 8. Per the Court's instructions at the October 3 status conference, this motion focuses on the remedies that are available and the form that a writ of mandamus should take.

ARGUMENT

The Court should grant summary judgment in Plaintiffs' favor, for the reasons already explained in the Court's September 19 opinion denying the Secretary's motion to stay. An order granting summary judgment and issuing a writ of mandamus should direct the Secretary to implement specific categories of reforms designed to remedy the existing backlog and to slow the pace of incoming appeals. In the alternative, the Court should affirm the availability of such reforms and should order numerical targets for improvement, including the full elimination of the

backlog by the end of 2020. Under either option, the Court should also require the Secretary to submit status reports every 60 days.

I. The Court Should Require The Secretary To Implement Specific Reforms That Address Both The Existing Backlog And The Future Pipeline.

The current backlog continues to grow: The ALJ hearings that the statute requires within 90 days are now taking more than ten times that, an average of 935.4 days. HHS, Office of Medicare Hearings and Appeals (OMHA), *Workload Information and Statistics* (July 25, 2016), www.hhs.gov/about/agencies/omha/about/current-workload/index.html. And the Secretary's most recent estimate presented to this Court is that the administrative appeals backlog will stand at more than 700,000 appeals at the end of this year. *See* Decl. of Ellen Murray Ex. 1 (May 25, 2016), ECF No. 30-1. Any remedy must contain a retrospective component to reduce the wait time for those appeals already in line. It must also mitigate the severe financial effects on hospitals waiting in appeal purgatory. And it must contain a prospective component to reduce the number of appeals that join the end of the line.

A. The Secretary Must Offer Broad, Reasonable Settlements.

The most efficient, concrete way for the Secretary to cut down on the existing backlog is by pursuing broad settlements. The Centers for Medicare & Medicaid Services (CMS) has taken this step before. In 2014, CMS offered hospitals the option to settle certain inpatient status claims for 68 cents on the dollar. *Id.* ¶ 19; *see also* Fund for Access to Inpatient Rehabilitation Amicus Br. 9-10 (June 20, 2016), ECF No. 32-1. Eligible hospitals were free to choose whether to take the offer or to continue to wait in line. At the October 3 status conference, counsel for the Government indicated that the inpatient status settlement will be extended to some additional claims.

The Court should order the Secretary to further expand the CMS settlement program. Most broadly, the Secretary could extend the 68% settlement offer to *all* hospitals or to *all* Medicare Part A providers; as with the recent settlement, providers could choose whether to accept or to soldier on. More narrowly, the Secretary could offer reasonable settlements to significant swaths of providers and suppliers who share broad commonalities, including inpatient rehabilitation facilities, skilled nursing facilities, suppliers of durable medical equipment, and so on.

B. The Secretary Must Delay Repayment And Toll Interest Accrual.

While the backlog remains significant, the Secretary must take other actions to alleviate the financial consequences of wait times that have stretched into many multiples of the statutory deadlines. To that end, the Court should order the Secretary to defer repayment of disputed claims and toll the accrual of interest on those claims for all periods of time for which an appeal is pending *beyond the statutory maximum* for any level of administrative review.[1] Both components are critical: A delay in repayment means that the plaintiff hospitals and others whose payments were clawed back in post-payment review can maintain control of the capital that they need for operations and improvements—which, as Plaintiffs have already noted, is particularly important to the almost 30% of hospitals operating with negative margins. *See* AHA, *Trendwatch Chartbook 2013: Trends Affecting Hospitals and Health Systems* 39, chart 4.1 (2013), http://www.aha.org/research/reports/tw/chartbook/2013/13chartbook-full.pdf. A delay in the accrual of interest, meanwhile, means that unsuccessful claimants will not be penalized by hefty and ever-growing interest payments. Nor should they be, when the statutory deadlines preclude the accrual of significant interest by requiring HHS to resolve claims within a year.

[1] For an administratively simpler solution, interest could instead by tolled until the date of an ALJ decision.

There are multiple ways that the Secretary could defer repayment and interest accrual. Most notably, the Secretary has express authority to conduct "demonstration projects" related to the provision of health care. 42 U.S.C. § 1395b-1(a). As relevant here, the Secretary may use her demonstration authority "to develop or demonstrate improved methods for the investigation and prosecution of fraud in the provision of care or services" under Medicare programs. *Id.* § 1395b-1(a)(1)(J). Because the post-payment review of Medicare reimbursement is such a "method[]," the Secretary has the authority to adopt demonstration projects to improve that post-payment review process. Delaying repayment and interest penalties would effect a substantial improvement for those providers and suppliers stuck waiting in line due to no fault of their own. And if the Secretary elects not to exercise her demonstration authority to provide relief to *all* claimants, she can at least reach a substantial subset of claimants. For example, she might limit the demonstration to hospitals or other Part A providers, who are suffering most acutely from the delays in the appeals process and whose financial difficulties most directly affect the public health. Or she might limit the demonstration to providers whose pending claims exceed a certain monetary threshold. If, say, the demonstration applied to all providers whose pending claims, in the aggregate, exceeded $10,000, it would provide relief to those claimants with the most money at stake, that would otherwise be penalized severely by accumulating interest and hamstrung by their inability to obtain access to critical funds.

There are other means, too, of enacting this reform. The Secretary may also conduct a demonstration "to determine whether, and if so which, changes in methods of payment or reimbursement . . . for health care and services under health programs established by this chapter, including a change to methods based on negotiated rates, would have the effect of increasing the efficiency and economy of health services under such programs through the

creation of additional incentives to these ends without adversely affecting the quality of such services." 42 U.S.C. § 1395b-1(a)(1)(A). Because a delay in repayment would save HHS from paying interest on categories of claims frequently overturned by an ALJ, that change might boost the "efficiency and economy of health services" (and a delay in interest accrual would be a necessary corollary). Alternatively, the Center for Medicare and Medicaid Innovation within CMS is empowered "to test innovative payment and service delivery models to reduce program expenditures," *id.* § 1315a(a)(1), which could be justified under a similar rationale. The Secretary is instructed to select models that "improve the coordination, quality, and efficiency of health care services." *Id.* Permitting hospitals to retain the capital sorely needed for purchasing equipment and offering certain services, particularly in rural areas, would accomplish just that. *See, e.g.*, Mot. for Summ. J. 22-23 (detailing plaintiff hospitals' struggles from lack of available capital).

The Secretary has previously protested that she is statutorily barred from suspending repayment of disputed claims and from tolling interest accrual for waiting times beyond the statutory maximums. *See* Def.'s Reply in Supp. of Mot. for Stay 22 (July 1, 2016), ECF No. 36. She points to two statutory provisions that she believes say so: 42 U.S.C. § 1395ddd(f)(2)(B) and 31 U.S.C. § 3711. Neither prevents the reforms that Plaintiffs propose.

First, the Medicare Act provides that "interest on the overpayment shall accrue on and after the date of the original notice of overpayment." 42 U.S.C. § 1395ddd(f)(2)(B).[2] But the statutory deadlines require that, as a general matter, "appeals will work their way through the administrative process within about a year." *Am. Hosp. Ass'n*, 812 F.3d at 186. Because HHS is

[2] This limitation applies to interest accrual only. There is no comparable statutory restriction fixing the time for repayment. *Cf.* 42 U.S.C. § 1395ddd(f)(2)(A) (providing that the Secretary may not require repayment *earlier* than the date of a Qualified Independent Contractor decision).

responsible for much longer delays, HHS should not be entitled to recover several years' worth of interest from claimants, when proper implementation of the statute would never allow such large amounts of interest to accrue. In fact, in other circumstances in which *providers and suppliers* are responsible for a delay that might work to the *Secretary's* detriment, HHS regulations toll the accrual of interest. *See* 42 U.S.C. § 1395ddd(f)(2)(B) (requiring Secretary to pay same interest rate as providers); 42 C.F.R. § 405.378(j)(3)(iv)-(v) (providing for tolling for certain claimant-induced delays).[3] HHS should do the same here.

In any event, even if there were no general statutory authority for tolling interest accrual, there is specific statutory authority for tolling in the context of a demonstration project or model. For demonstrations, the Secretary may "waive compliance with" other statutory requirements that "relate to reimbursement or payment"—including rules governing repayment and interest accrual—"for such services or items as may be specified in the experiment." 42 U.S.C. § 1395b-1(b). The same goes for payment models. *See id.* § 1315a(d)(1).

Second, a generally applicable federal statute provides that heads of agencies "shall try to collect a claim of the United States Government for money or property arising out of the activities of, or referred to, the agency." 31 U.S.C. § 3711. That provision does not impose a blanket rule that an agency must recoup payment as soon as permissible, or must charge interest on that claim even when the agency is responsible for delays in its resolution. Indeed, HHS's own regulations provide that "[t]he Secretary may suspend collection activity on a debt" if a

[3] Flip the parties, and CMS's explanation for its tolling regulations applies just as well here: "We believe that our proposal to deduct the days that are associated with an appellant's actions aligns itself with the language in the appeals regulations. *CMS should not be required to pay interest on days that the appellant is in control of*, or is perfecting an appeal request, *or takes action that delays the administrative proceedings*." *Medicare Program; Limitation on Recoupment of Provider and Supplier Overpayments*, 74 Fed. Reg. 47,458, 47,462 (Sept. 16, 2009) (emphases added).

"debtor has requested a waiver or review of the debt." 45 C.F.R. § 30.29(a). The ordinary responsibility of government agencies to collect debts owed them does not tie the Secretary's hands here.

Importantly, these changes would not just ease the financial pain for providers and suppliers; they would create an appropriate incentive for the Secretary to put her best efforts toward resolving the backlog. As things stand, HHS retains the funds recovered by Medicare contractors (whether RACs or others) during the entire appeals process. As a result, the Secretary has no financial incentive to expedite the appeals process to bring it in line with the statutory deadlines. Basic economics dictate that implementing these changes to repayment and interest accrual will force HHS to resolve the backlog more quickly.

C. The Secretary Must Penalize RACs For Poor Performance At The ALJ Level.

Finally, the Secretary must take action to slow the influx of new appeals. This can be best accomplished by reining in the abuses of RACs. Over half of the appeals filed at the ALJ level in fiscal years 2010-2014 were RAC-related. *See* U.S. Gov't Accountability Office, *Medicare Fee-for-Service: Opportunities Remain to Improve Appeals Process* 61 (May 2016) (*GAO Report*).[4] Perhaps even more importantly, providers' RAC-related appeals are likely to succeed: In 2014, ALJs fully reversed RACs' overpayment decisions in Part A appeals 57% of the time. *Id.* at 69. Both the Court of Appeals and this Court have acknowledged that the RAC program is a problem, and that it is a problem the Secretary has the tools to fix. *See Am. Hosp.*

[4] The Secretary has previously argued RAC-related appeals have dipped thus far this fiscal year. *See* Decl. of Ellen Murray 6-7. But that trend relates to a temporary change in RAC contracts and two moratoria—one imposed by Congress and the other by CMS—on RAC review of short inpatient hospitals stays. *See* CMS, Medical Review and Education, *Inpatient Hospital Reviews* (Sept. 28, 2016), https://goo.gl/sXwvud. HHS has "reported that it expects the number of incoming appeals to increase again when new [RAC] contracts are awarded and the [RAC] program resumes full operation." *GAO Report* 38.

Ass'n, 812 F.3d at 187 ("the RAC program has contributed to a drastic increase in the number of administrative appeals"); *id.* at 186 ("[Congress] left the Secretary broad discretion to determine many other [RAC] program details"); Mem. Op. 13 ("The scope of the initiatives involving the RAC Program give the Court particular pause.").

The Court should order the Secretary to implement a more effective check on the RAC program by imposing financial penalties on RACs for high reversal rates. In order to effectively deter indefensible claim denials, the financial penalties must be significant and must be linked to a meaningful level of the appeals process. The Secretary has, for example, noted that RACs with low reversal rates may receive bonuses, and that RACs with high reversal rates may not have their contracts renewed. *See* Reply in Supp. of Mot. for Stay 21-22. As Plaintiffs have explained before, however, such incentives are linked only to the early levels of review, not review at the ALJ level—the level at which RACs' success rates are abysmally low. *Compare GAO Report* 64 (11.1% reversal rate at Medicare Administrative Contractor level for Part A appeals in 2014); *id.* at 66 (20.8% reversal rate at Qualified Independent Contractor level), *with id.* at 69 (57% reversal rate at ALJ level). Small financial incentives for affirmances at the rubber-stamp levels are not enough; significant penalties for reversals at the ALJ level are necessary.

The Secretary should choose how best to implement such penalties. She might, for example, modify the terms of the standard RAC statement of work. *See* CMS, *Statement of Work for Recovery Audit Program*, http://goo.gl/teh6c8 (last visited Oct. 13, 2016). The statement of work currently provides that RACs must repay their contingency fee if their overpayment determination is reversed at any level. *Id.* at 49. The Secretary could change that term to require repayment of the contingency fee *plus* a penalty, calculated as a percentage of the

initially recouped claim. Alternatively, the Secretary might provide a tiered fee schedule under which RACs receive a diminishing contingency fee percentage when their total error rate at the ALJ level increases. That approach would have the added benefit of putting the worst offenders out of the RAC business altogether.

If the Secretary refuses to adopt a penalty structure to provide incentives to the RACs to improve their accuracy, then more sweeping reforms of the RAC program may be necessary. Among the possibilities: shortening the RAC lookback period from three years to one year, *see id.* at 9; 42 U.S.C. § 1395ddd(h)(4); suspending denials for isolated failures to satisfy documentation deadlines or comparable technical errors; or suspending all medical-necessity audits unless there is evidence of fraud. There is, in short, much work to be done and many ways to do it.

* * *

Although the basis for any grant of mandamus is the Secretary's failure to comply with clear statutory deadlines, the Secretary has stated that a bare writ of mandamus instructing her to comply with those deadlines will not be followed. *See* Mot. for Stay 30 ("there has been no suggestion that the immediate issuance of a writ would succeed in expediting these hospitals' appeals to any greater extent"). The three reforms described above offer real solutions to remedy the Secretary's continued statutory violations. The Court should therefore order the Secretary to implement some meaningful version of all three reforms, or to offer and implement proposals of her own that would have *at least as significant an effect* on reducing the backlog and on minimizing its impact in the interim. *See Peoples v. U.S. Dep't of Agriculture*, 427 F.2d 561, 565 (D.C. Cir. 1970) (explaining that the "liberalizing purpose" of 28 U.S.C. § 1361 was "to permit District Courts generally to issue appropriate corrective orders"); *see also U.S. ex rel.*

Rahman v. Oncology Assocs., P.C., 198 F.3d 502, 511 (4th Cir. 1999) ("While the writ is recognized at law, it is administered with equitable principles in the interest of justice and at the discretion of the issuing court."). The Secretary cannot continue criticizing imperfect solutions without offering alternative solutions of her own.

II. Alternatively, The Court Should Require The Secretary To Meet Numerical Targets Through 2020.

In the alternative, if the Court is reluctant to cabin the Secretary's discretion in resolving the backlog—notwithstanding the Secretary's asserted inability to comply with the statute on her own—it should take two actions instead. First, it should affirm the legal availability of the above three reforms, lest the Secretary incorrectly equate her discretionary policy choices with statutory mandates. Second, it should order the Secretary to comply with specific numerical targets. Plaintiffs recognize that their proposals (or comparable programmatic changes of the Secretary's own) will bear fruit at different times. Plaintiffs thus propose that the Court order the following deadlines, which will bring the Secretary into compliance with the statute by the start of 2021:

- A **30% reduction** from the current backlog of cases pending at the ALJ level by December 31, 2017.
- A **60% reduction** from the current backlog of cases pending at the ALJ level by December 31, 2018.
- A **90% reduction** from the current backlog of cases pending at the ALJ level by December 31, 2019.
- **Elimination of the backlog** of cases pending at the ALJ level by December 31, 2020.
- On January 1, 2021, default judgment in favor of all claimants whose appeals have been pending at the ALJ level without a hearing for more than one calendar year.

This proposal sets aggressive but attainable targets for the Secretary to bring HHS into compliance with its statutory mandates. It also gives Congress significant time to intervene, if it should so choose. And if neither political branch acts in the next *four years*, then it imposes a substantial penalty on HHS for non-compliance. After Medicare providers and suppliers have

borne the costs of HHS's non-compliance for years, shifting those costs to the Secretary is an appropriate exercise of this Court's equitable powers.

III. The Court Should Require The Secretary To File Status Reports Every 60 Days.

Regardless of whether the Court requires specific categories of reform or specific numerical targets, the Secretary must account for her progress toward statutory compliance. The Court should order the Secretary to file a status report every 60 days. Each status report should provide (1) updated figures reflecting the current and projected appeals backlog; and (2) a description of any significant changes that will affect the backlog, including settlements, new HHS policies, new legislation, increased appropriations, and the like.

In the ordinary course, these status reports will require no response from the Court or from Plaintiffs. If, however, the Secretary makes little or no progress on the substantive proposals that the Court orders or the numerical targets that it sets, Plaintiffs reserve the right to move for additional or more specific forms of relief.

CONCLUSION

For the foregoing reasons, Plaintiffs respectfully request that the Court grant their motion for summary judgment and that mandamus issue.

Respectfully submitted,

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Dated: October 14, 2016

CERTIFICATE OF SERVICE

I hereby certify that on October 14, 2016, I electronically filed the foregoing with the Clerk of Court using the CM/ECF system.

/s/ Catherine E. Stetson
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